MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09750

CERTIFICATE OF DEATH

09723 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: Lifetime
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 600 National Highway-La Vale

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 Cumberland
d. STREET ADDRESS: 600 National Highway-La Vale
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Lula; Middle: L.; Last: Boden

4. DATE OF DEATH: Month: 9; Day: 2; Year: 1959

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Oct. 8, 1898

9. AGE (In years last birthday): 60 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Cumberland, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Franklin W. Hammersmith

14. MOTHER'S MAIDEN NAME: Mary Frances Robinson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: none

INFORMANT: Jack D. Boden, Cumberland, Md. (Address)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Uremia — INTERVAL BETWEEN ONSET AND DEATH: 1 week
DUE TO (b): Ureteral obstruction
DUE TO (c): Carcinoma of cervix with metastasis — 2 1/2 yrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

171X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from ____, 1957, to Sept 2, 1959, that I last saw the deceased alive on Sept 1, 1959, and that death occurred at 4 P. M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Thomas F. Lewis M.D.
ADDRESS (Street, city or town, state): Cumberland at Washington St.
DATE SIGNED: Sept. 3, 1959

PHYSICIAN'S NAME (Type): Thomas F. Lewis, MD — Cumberland, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9-5-59
22c. NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park
22d. LOCATION (City, town, or county) (State): Cumberland, Md.

23. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: James F. Scarpelli, Cumberland, Md.

24a. REC'D BY REGISTRAR DATE: SEP 8 '59

24b. REGISTRAR'S SIGNATURE: Arthur L. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09751 — 09724 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland,
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Memorial Hosp. D.O.A.

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: W. Va. — b. COUNTY: Mineral
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ridgeley,
d. STREET ADDRESS: 4 Carpenter Ave.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Retta — Middle May — Last Brant
4. DATE OF DEATH: Month Sept. — Day 24, — Year 1959
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Sept. 24, 1871
9. AGE (In years last birthday): 88 yrs.
IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife,
10b. KIND OF BUSINESS OR INDUSTRY: Own home
11. BIRTHPLACE (State or foreign country): Sharpsburg, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Jonathan Moats
14. MOTHER'S MAIDEN NAME: Margaret Stobbs
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No, — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Mr. Arthur E. Brant — Address: Ridgeley, W. Va. 4 Carpenter Ave.,

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: sudden
420.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) coronary sclerosis
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Benedict Skitarelic M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: Sept. 24, 1959
EXAMINER'S NAME (Type): Dr. Benedict Skitarelic

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9/26/59
22c. NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park
22d. LOCATION (City, town, or county) (State): Cumberland, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE: H. Wayne George — ADDRESS: Cumberland, Md.
24a. REC'D BY REGISTRAR DATE: SEP 28 59
24b. REGISTRAR'S SIGNATURE: Arthur L Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09725

09803 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport-Rural
c. LENGTH OF STAY IN 1b ~~23 Hrs~~ 2 Ds.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1 mile East of Westernport

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport 43
d. STREET ADDRESS Green St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First McComas Middle Broadwater Last
4. DATE OF DEATH Month Sept. Day 17 Year 1959.

5. SEX Male
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH Jan. 13, 1893
9. AGE (In years last birthday) 66 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer
10b. KIND OF BUSINESS OR INDUSTRY Farm
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Kennerd Broadwater
14. MOTHER'S MAIDEN NAME Annie Wiland

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Address Mrs. Joseph Grandstaff-Suitland, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Strangulation by Rope around neck
DUE TO (b)
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 974X
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Hanged self by neck by rope
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE W O McLane M.D.
EXAMINER'S NAME (Type) W O McLane md
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED Sept 14 1959

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 9/21/59
22c. NAME OF CEMETERY OR CREMATORY Laurel Hill
22d. LOCATION (City, town, or county) (State) Moscow Md.

23. FUNERAL DIRECTOR'S SIGNATURE C E Beall
ADDRESS Westernport, Md.
24a. REC'D BY REGISTRAR DATE SEP 22 '59
24b. REGISTRAR'S SIGNATURE Arthur L. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for [illegible] files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME 5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09752

CERTIFICATE OF DEATH

09726

Reg. Dist. No.

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: Mins.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: D.O.A. Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: W. Va. b. COUNTY: Mineral
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Wiley Ford 85X-3
d. STREET ADDRESS: Holland Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Violet Middle: Pearl Last: Browning
4. DATE OF DEATH: Month: Sept. Day: 24 Year: 19 59
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Feb. 27, 1918
9. AGE (In years last birthday): 41 yrs. IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Cumberland, Md.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: James T. Shrout
14. MOTHER'S MAIDEN NAME: Mary F. Stonebraker
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 214-07-6410
17. INFORMANT: Address: Mr. Irvin Browning, Wiley Ford, W. Va.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH: 2 hours.
DUE TO
410X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Mitral stenosis
DUE TO
(c) Rheumatic fever

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour: a. m. p. m. Month: Day: Year: 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Sept. 22, 19 59, to Sept. 24, 19 59, that I last saw the deceased alive on Sept. 24, 19 59, and that death occurred at 1:05 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D. — ADDRESS (Street, city or town, state): 133 Virginia Avenue — DATE SIGNED: 9-25-59

PHYSICIAN'S NAME (Type): G. Overton Himmelwright, M.D. Cumberland, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9-27-1959
22c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park
22d. LOCATION (City, town, or county) (State): Cumberland, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: James F. Scarpelli, Cumberland, Md.
24a. REC'D BY REGISTRAR DATE: SEP 29 '59
24b. REGISTRAR'S SIGNATURE: Clifton L. Hann

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09727

09753

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 58yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 216 Arch Street

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland 02
d. STREET ADDRESS: 216 Arch Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Jasper Middle: Carl Last: Bucy

4. DATE OF DEATH: Month: Sept Day: 29, Year: 1959

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Dec. 18, 1885

9. AGE (In years last birthday): 73 yrs.
IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Bottle Washer

10b. KIND OF BUSINESS OR INDUSTRY: Milk Plant

11. BIRTHPLACE (State or foreign country): Towncreek, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Denton B. Bucy

14. MOTHER'S MAIDEN NAME: Mary Huff

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 214-05-8033A

17. INFORMANT: Nellie Mae Redhead Address: same as above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cor Pulmonale — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs

DUE TO (b): Chronic Asthmatic Bronchitis — 5 yrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

501 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 7/24/57, 19____, to 9/29/59, 19____, that I last saw the deceased alive on 9/28/59, 19____, and that death occurred at 8:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: O J Mullennex M.D. ADDRESS (Street, city or town, state): Cumberland DATE SIGNED: 9/30/59

PHYSICIAN'S NAME (Type): Richard J. Williams 122 N. Centre St. Cumberland, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 10-2-59

22c. NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park

22d. LOCATION (City, town, or county) (State): Cumberland, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: James F. Scarpelli ADDRESS: Cumberland, Md.

24a. REC'D BY REGISTRAR DATE: OCT 5 '59

24b. REGISTRAR'S SIGNATURE: Evelyn S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death

VS A1S (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09754

CERTIFICATE OF DEATH

09728
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 3 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LONACONING
d. STREET ADDRESS: Detmold
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First EMMA; Middle; Last CAMERON

4. DATE OF DEATH: Month SEPTEMBER; Day 3; Year 1959

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: OCTOBER 13, 1886

9. AGE (In years last birthday): 72 yrs
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS: Hours; Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Work

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ROBERT MOFFATT

14. MOTHER'S MAIDEN NAME: MARTHA STARBRIGHT

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): NO

16. SOCIAL SECURITY NO: NONE

INFORMANT: MEMORIAL HOSPITAL, Address: CUMBERLAND, MARYLAND

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Arteriosclerotic Cardio — INTERVAL BETWEEN ONSET AND DEATH: Unknown

422.1

DUE TO (b): Vascular Disease

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c): Congestive heart failure (?)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 8-31-, 1959 to 9-3-, 1959 that I last saw the deceased alive on 9-2-, 1959, and that death occurred at 7:43 AM from the causes and on the date stated above.

ACTUAL SIGNATURE: W. F. Williams — ADDRESS (Street, city or town, state): Cumberland, Md — DATE SIGNED: 9-3-59

PHYSICIAN'S NAME (Type): W.F.WILLIAMS

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 9/6/1959

22c. NAME OF CEMETERY OR CREMATORY: Oak Hill Cemetery

22d. LOCATION (City, town, or county) (State): Lonaconing, MD.

23. FUNERAL DIRECTOR'S SIGNATURE: GEORGE EICHHORN — ADDRESS: LONACONING, MD.

24a. REC'D BY REGISTRAR DATE: SEP 8 '59

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraas

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09755

CERTIFICATE OF DEATH

09729

Reg. Dist. No.

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/[redacted]

1. PLACE OF DEATH a. COUNTY: ALLEGANY — MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: MARYLAND b. COUNTY: ALLEGANY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND c. LENGTH OF STAY IN 1b: 11 DAYS	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X LA VALE
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: MEMORIAL HOSPITAL	d. STREET ADDRESS: 329 NATIONAL HIGHWAY e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)	First: B.	Middle: HARRISON	Last: CARL	4. DATE OF DEATH	Month: SEPTEMBER	Day: 25	Year: 1959
5. SEX: MALE	6. COLOR OR RACE: WHITE	7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH: 11-22-1889	9. AGE (In years last birthday): 69 yrs	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS: Hours / Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED	10b. KIND OF BUSINESS OR INDUSTRY: Railroad clerk	11. BIRTHPLACE (State or foreign country): HANCOCK, MARYLAND	12. CITIZEN OF WHAT COUNTRY?: U.S.A.				
13. FATHER'S NAME: DANIEL CARL	14. MOTHER'S MAIDEN NAME: ANNIE SPRENKLE						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): Yes (If yes, give war or dates of service): W W I	16. SOCIAL SECURITY NO: 705-10-4581	INFORMANT: WARWICK & MEMORIAL AVENUE MEMORIAL HOSPITAL - CUMBERLAND MD.					

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Benign hypertrophy prostate — INTERVAL BETWEEN ONSET AND DEATH: ?

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): Arteriosclerosis, Coronary sclerosis

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour: o. m. / p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 9-14-59 to 9-25-59 that I last saw the deceased alive on 9-24 1959 and that death occurred at 4:30 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Howard L. Tolson M.D. ADDRESS (Street, city or town, state): Cumberland, Md. DATE SIGNED: 9-25-59

PHYSICIAN'S NAME (Type): DR. HOWARD L. TOLSON

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial	22b. DATE THEREOF: 9/27/59	22c. NAME OF CEMETERY OR CREMATORY: RoseHill Cemetery	22d. LOCATION (City, town, or county) (State): Cumberland Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE: Ruth E. Silcox	ADDRESS: Cumberland Maryland	24a. REC'D BY REGISTRAR DATE: SEP 29 '59	24b. REGISTRAR'S SIGNATURE: Carlton A. Mathias	

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09756

CERTIFICATE OF DEATH

09730 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Sacred Heart Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland,
d. STREET ADDRESS: 202 Columbia St. City.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Norman Middle E Last Chirdon

4. DATE OF DEATH: Month September Day 7, Year 1959

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 4/12,-1915
9. AGE (In years last birthday): 44 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman
10b. KIND OF BUSINESS OR INDUSTRY: Lumber Co.
11. BIRTHPLACE (State or foreign country): Pa.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles Chirdon
14. MOTHER'S MAIDEN NAME: Gertrude Conrad

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
INFORMANT: Wife Jane
Address: 202 Columbia St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Infaretion — Interval between onset and death: 1 hour
DUE TO
420.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Coronary Artery Disease — 2-3 years
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from January, 1958, to September, 1959 that I last saw the deceased alive on Sept. 7, 1959, and that death occurred at 4:15 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: William P. James M.D. ADDRESS (Street, city or town, state): 141 N. Centre St DATE SIGNED: 9.9.59

PHYSICIAN'S NAME (Type): Dr. William P. James Cumberland, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9/10/59
22c. NAME OF CEMETERY OR CREMATORY: St. Peter + Paul
22d. LOCATION (City, town, or county) (State): Cumberland Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Louis Steinberg ADDRESS: Cumb. Md.

24a. REC'D BY REGISTRAR DATE: SEP 11 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Kuhns

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SB

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09731

Reg. Dist. No. 09731

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 8 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): SACRED HEART HSOPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: WEST VIRGINIA — b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): PAW PAW
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Patricia — Middle — Last: Clark

4. DATE OF DEATH: Month: Sept. — Day: 30 — Year: 1959

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH: MARCH 21, 1939

9. AGE (In years last birthday): 20 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): WEST VIRGINIA

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: HOMER PARKER

14. MOTHER'S MAIDEN NAME: MARY BOWERS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT — Address: PATIENTS CHART

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Pulmonary Embolism, Massive — INTERVAL BETWEEN ONSET AND DEATH: 10 Minutes

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☒, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: Sept. 30, 1959

EXAMINER'S NAME (Type): Benedict Skitarelic, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: OCT. 3, 1959
22c. NAME OF CEMETERY OR CREMATORY: Woodrow Mem.
22d. LOCATION (City, town, or county) (State): PAW PAW, W. VA.

23. FUNERAL DIRECTOR'S SIGNATURE: H. L. Bruce — ADDRESS: Parks Funeral Home Berkeley Springs

24a. REC'D BY REGISTRAR — DATE OCT 5 '59
24b. REGISTRAR'S SIGNATURE: Arthur A. Kuns

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09758

CERTIFICATE OF DEATH

09732

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 11days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Sacred Heart Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution Res dence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
d. STREET ADDRESS: 415 N Mechanic Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Theresa Middle Elizabeth Last Cline
4. DATE OF DEATH: Month Sept. Day 22 Year 19 59
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 4/1/98
9. AGE (In years last birthday): 61 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own home
11. BIRTHPLACE (State or foreign country): Cumberland, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Lloyd Ryland (Dec)
14. MOTHER'S MAIDEN NAME: Margaret Brodigan (Dec)
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No, (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
INFORMANT: Mrs. Kenneth Imler Address: Altoona, Penna.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary atelectasis bilateral — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Myocardial ischemia —
DUE TO
(c) Coronary artery insufficiency —

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Duodenal obstruction due to chronic duodenitis & pericholecystitis
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from Sept 17, 1959, to Sept 21, 1959, that I last saw the deceased alive on Sept 20, 1959, and that death occurred at 8:14 A.M., from the causes and on the date stated above.
ACTUAL SIGNATURE: Thomas F. Lewis M.D.
ADDRESS (Street, city or town, state): Hotel Algonquin Cumberland Maryland
DATE SIGNED: Sept 24, '59
PHYSICIAN'S NAME (Type): THOMAS F. LEWIS M.D. ~~Dr. H. P. Jones~~ 141 N. Mechanic St.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9/25/59
22c. NAME OF CEMETERY OR CREMATORY: St. Patrick's Cem.
22d. LOCATION (City, town, or county) (State): Cumberland, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: H. Wayne George ADDRESS: Cumberland, Md.
24a. REC'D BY REGISTRAR DATE: SEP 28 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Kimes

VS A15 (4)
1SM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09759 — Reg. Dist. No. 09733

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland,
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 119 So. Allegany St.,

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland,
d. STREET ADDRESS: 119 So. Allegany St.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CHARLES — Middle LEO — Last COLLINS
4. DATE OF DEATH: Month Sept. — Day 19, — Year 19 59

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: June 13, 1904
9. AGE (In years last birthday): 55 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Self-employed barber
10b. KIND OF BUSINESS OR INDUSTRY: Barbering
11. BIRTHPLACE (State or foreign country): Massachusetts
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No, (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 060-10-4901
17. INFORMANT: Mr. James Alfred Avirett 1, Address: Washington St. Cumb. Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary ; Occlusion — INTERVAL BETWEEN ONSET AND DEATH: sudden

420.1

DUE TO (b): Coronary sclerosis — ------

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Benedict Skitarelic M.D. — DATE SIGNED

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): Benedict Skitarelic, M.D. — Sept. 20, 1959

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9/22/59
22c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park
22d. LOCATION (City, town, or county) (State): Cumberland, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: H. Wayne George — ADDRESS: Cumberland, Md.
24a. REC'D BY REGISTRAR DATE: SEP 23 '59
24b. REGISTRAR'S SIGNATURE: Orlan L. Travis

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A1SME(S) SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09760 **CERTIFICATE OF DEATH** Reg. Dist. No. 09734

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: ONE DAY
d. NAME OF HOSPITAL (If not in hospital, give street address OR INSTITUTION): MEMORIAL HOSPITAL — MEMORIAL & WARWICK AVES.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
d. STREET ADDRESS: 1418 RIVER AVE.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First BESSIE — Middle MAE — Last DAVIS

4. DATE OF DEATH: Month SEPTEMBER — Day 11 — Year 19 59

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: APRIL 3 1889

9. AGE (In years last birthday): 70 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): GROCERY STORE OWNER

10b. KIND OF BUSINESS OR INDUSTRY: GROCERY

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: JAMES INSKEEP

14. MOTHER'S MAIDEN NAME: ELIZABETH TRAVIS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

INFORMANT: MEMORIAL HOSPITAL — Address: CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Chronic Myocarditis — INTERVAL BETWEEN ONSET AND DEATH: 4 yrs
DUE TO (b): Arteriosclerosis
DUE TO (c): —

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
422.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes Mellitus

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 7/4/47 19___, to 9/11/59 19___, that I last saw the deceased alive on 9/11/59 19___, and that death occurred at 7:05 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: R. Williams M.D. — ADDRESS (Street, city or town, state): Cumberland — DATE SIGNED: 9/10/59

PHYSICIAN'S NAME (Type): DR. RICHARD J. WILLIAMS

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 9-14-59

22c. NAME OF CEMETERY OR CREMATORY: Wesley Chapel Cem

22d. LOCATION (City, town, or county) (State): Points, W.Va.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: James F. Scarpelli Cumberland, Md.

24a. REC'D BY REGISTRAR — DATE: SEP 17 '59

24b. REGISTRAR'S SIGNATURE: Esther S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
ISM 9/SB

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09804

CERTIFICATE OF DEATH

09735

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Midland
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Railroad Street

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Midland
d. STREET ADDRESS: Railroad Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First CHESTER; Middle; Last DAVIS

4. DATE OF DEATH: Month 9/21.1959; Day; Year 19

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 2/25/ 1895

9. AGE (In years last birthday): 64 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Celanese Employee

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Midland, MD.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Elijah Davis

14. MOTHER'S MAIDEN NAME: Hannah Boor

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO:

17. INFORMANT: Mrs. Hannah Davis, Midland, MD. (Mother)
Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hypertensive Cardiovascular Disease — INTERVAL BETWEEN ONSET AND DEATH: Years
DUE TO
420.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Coronary Dis. — 1 day
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from [illegible], 19[illegible], to Sept 21, 19[illegible], that I last saw the deceased alive on 9/21/59, 19—, and that death occurred at 9:35 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: John R. Davis, M.D. — ADDRESS (Street, city or town, state): 2 Broadway — DATE SIGNED

PHYSICIAN'S NAME (Type): John R Davis M.D. — Frostburg Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 9/23/1959

22c. NAME OF CEMETERY OR CREMATORY: Memorial Park

22d. LOCATION (City, town, or county) (State): Frostburg, MD.

23. FUNERAL DIRECTOR'S SIGNATURE: GEORGE EICHHORN — ADDRESS: LONACONING, MD.

24a. REC'D BY REGISTRAR DATE: SEP 25 '59

24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 10/57

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09761

CERTIFICATE OF DEATH

09736

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death

VS A15 (4)
1SM 9/58

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Sacred Heart Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Cresaptown
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Martha Middle: E Last: Dawson

4. DATE OF DEATH: Month: 9 Day: 17 Year: 1959

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 9-11-1883

9. AGE (In years last birthday): 76 yrs.
IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HRS: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Maryland Dawson

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: Dawson, Theodore

14. MOTHER'S MAIDEN NAME: Taylor, Susan

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO: None

INFORMANT: Mrs. Solomon Doss
Address: Daughter Cresaptown, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 6 months
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: a. m. / p. m. Month: Day: Year: 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.):

20f. (City or town) (County) (State):

21. I certify that I attended the deceased from Sept 1, 1959, to Sept 17, 1959, that I last saw the deceased alive on Sept 14, 1959, and that death occurred at 4:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: B. M. Schindler M.D. — ADDRESS (Street, city or town, state): 43 Greene Street Cumberland Md — DATE SIGNED: 9-19-59

PHYSICIAN'S NAME (Type): Dr. B. M. Schindler M.D. — 43 Greene Street, Cumberland, Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Sept. 20, 1959
22c. NAME OF CEMETERY OR CREMATORY: Hillcrest Cemetery
22d. LOCATION (City, town, or county) (State): Cumberland, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: John J. Hafer, Cumberland, Maryland — ADDRESS:

24a. REC'D BY REGISTRAR DATE: SEP 22 '59

24b. REGISTRAR'S SIGNATURE: Esther L. Krause

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09737

Items 4,21 Filed 9-28-59 et

09762

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: Lifetime
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 111 Oak St.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
d. STREET ADDRESS: 111 Oak St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: James — Middle: Waldron — Last: Day

4. DATE OF DEATH: Month: Sept. — Day: 15 — Year: 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Dec. 11, 1891

9. AGE (In years last birthday): 67 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Painter

10b. KIND OF BUSINESS OR INDUSTRY: Railroad

11. BIRTHPLACE (State or foreign country): Cumberland, Md.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: James H. Day

14. MOTHER'S MAIDEN NAME: Jessie Mudge

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): yes (If yes, give war or dates of service): WAR I

16. SOCIAL SECURITY NO.: 705-09-.883

17. INFORMANT: Address: Mrs. James Day, Cumberland, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Carcinoma of Colon — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs

DUE TO (b): Metastasis to Liver — —

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): — —

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: o. m. / p. m. — Month: — Day: — Year: 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) Cumb Alleg (State) Md

21. I certify that I attended the deceased from 7/2/54, 19—, to 9/12/59, 19—, that I last saw the deceased alive on 9/13/59, 19—, and that death occurred at 10:42 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: R. J. Williams M.D.

ADDRESS (Street, city or town, state): 122 S. Centre St.

DATE SIGNED:

PHYSICIAN'S NAME (Type): Richard J. Williams, MD. — Cumberland, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 9-19-1959

22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

22d. LOCATION (City, town, or county) (State): Cumberland, Md.

23. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: James F. Scarpelli, Cumberland, Md.

24a. REC'D BY REGISTRAR DATE: SEP 21 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [redacted] hours after death. [redacted] Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the [redacted] funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 10/57

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09738

Reg. Dist. No. 09763

1 PLACE OF DEATH
a. COUNTY Allegany MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland
c. LENGTH OF STAY IN 1b 69 Da.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hosp.

2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE Maryland b. COUNTY Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland, Maryland
d. STREET ADDRESS 23 Fairview Ave
e. IS RESIDENCE ON A FARM YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Frederick Middle W. Last Frost
4. DATE OF DEATH Month Sept. Day 12 Year 1959
5. SEX Male
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH Sept. 15, 1887
9. AGE (In years last birthday) 72 yrs
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Laundry Worker
10b. KIND OF BUSINESS OR INDUSTRY Union Laundry
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Frederick Frost
14. MOTHER'S MAIDEN NAME Mary Dennowske

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT Address Mrs. Delphin Bucy, Cumb. Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Artery Disease — INTERVAL BETWEEN ONSET AND DEATH 3 years
DUE TO (b) Arteriosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Colitis — Fracture R/L ankle
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.) Pt was intoxicated & fell down stair
20c. TIME OF INJURY Hour 5 a.m. p.m. Month, Day, Year 7/5/59
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home 23 Fairview
20f. (City or town) Cumberland (County) Allegany (State) Md

21. I certify that I took charge of the remains described above, held on Autopsy ☒ Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE [signature] M D
EXAMINER'S NAME (Type)
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒ Acting
DATE SIGNED 9/14/59

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 9/16/59
22c. NAME OF CEMETERY OR CREMATORY Evergreen Cem.
22d. LOCATION (City, town, or county) Cumberland (State) Md.

23. FUNERAL DIRECTOR'S SIGNATURE [signature] ADDRESS Davis Stein Inc. Cumb Md.
24a. REC'D BY REGISTRAR DATE SEP 16 59
24b. REGISTRAR'S SIGNATURE Arthur L. Kuss

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME
BM 2.57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09764 09739

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND b. COUNTY: ALLEGANY

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 7 HOURS
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND, MARYLAND

d. NAME OF HOSPITAL (If not in hospital, give street address or location) OR INSTITUTION: MEMORIAL HOSPITAL — WARWICK & MEMORIAL AVES.
d. STREET ADDRESS: 100 SEYMOUR STREET
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First KENNETH Middle S. Last FULLER
4. DATE OF DEATH: Month SEPTEMBER Day 10 Year 1959

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: JULY 1, 1906
9. AGE (In years last birthday): 53 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Machinist
10b. KIND OF BUSINESS OR INDUSTRY: Textile, Yarn
11. BIRTHPLACE (State or foreign country): CUMBERLAND, MARYLAND
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: HARRY, FULLER
14. MOTHER'S MAIDEN NAME: ELIZABETH KRAUSE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: 214-07-2365
INFORMANT Address: MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CONGESTIVE HEART FAILURE — INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO (b): AORTIC INSUFFICIENCY — 15 yrs
DUE TO (c): OLD RHEUMATIC HEART DISEASE — Unknown

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): UPPER RESP. INFECT.; OLD RT HEMIPARESIS
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c TIME OF INJURY Hour a m p. m. Month, Day, Year 19
20d INJURY OCCURRED While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or Town) (County) (State)

21. I certify that I attended the deceased from ____ 19 46 to Sept 10 1959 that I last saw the deceased alive on Sept 10, 1959, and that death occurred at 5:00 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D.
ADDRESS (Street, city or town, state): 59 GREENE ST
DATE SIGNED: 9/12/59

PHYSICIAN'S NAME (Type): S G WEISMAN — CUMBERLAND, MD

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9-13-59
22c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park
22d. LOCATION (City, town, or county) (State): Cumberland, d.

23. FUNERAL DIRECTOR'S SIGNATURE: James F. Scarlelli ADDRESS: Cumberland, d
24a REC'D BY REGISTRAR DATE: SEP 17 '59
24b. REGISTRAR'S SIGNATURE: [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18.

09805 09740

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Allegany County Hill MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing
c. LENGTH OF STAY IN 1b Years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md. b. COUNTY Gall
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing
STREET ADDRESS Roosevelt Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Wilmoth Middle Garlitz Last
4. DATE OF DEATH Month Sept. Day 20 Year 1959
5. SEX m
6. COLOR OR RACE wh.
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 4/2/1900
9. AGE (In years last birthday) 59 yrs
IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stat. Helper
10b. KIND OF BUSINESS OR INDUSTRY Rr
11. BIRTHPLACE (State or foreign country) Hilton, MD
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Othea Garlitz
14. MOTHER'S MAIDEN NAME Annabel Durst
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 214-07-3264
17. INFORMANT Mrs. Wilmoth Garlitz "Wife" Address Lonaconing Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH
420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO (b) Arteriosclerotic cardiovascular dis Years
DUE TO (c) Arteriosclerosis
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Duodenal ulcer
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from March, 19 59 to Sept, 19 59 that I last saw the deceased alive on Sept, 19 59 and that death occurred at 2 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE George Eichhorn M.D ADDRESS (Street, city or town, state) 27, Main Street DATE SIGNED
PHYSICIAN'S NAME (Type) George Eichhorn Lonaconing, Md

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 9/23/59
22c. NAME OF CEMETERY OR CREMATORY St. Marys Cemetery
22d. LOCATION (City, town, or county) Lonaconing, (State) Md.

23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn ADDRESS Lonaconing, Md.
24a. REC'D BY REGISTRAR DATE SEP 23 '59
24b. REGISTRAR'S SIGNATURE Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 4 f 13,247, 13-1-59 et

09765

CERTIFICATE OF DEATH

Reg. Dist. No. 03741

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 1/9/1956
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Allegany County Infirmary

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Mt. Savage
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Lillian; Middle: Belle; Last: Grady

4. DATE OF DEATH: Month: Sept; Day: 22; Year: 19 59

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 9/4/1889

9. AGE (In years last birthday): 70 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY: U. S. A.

13. FATHER'S NAME: Winfield Porter

14. MOTHER'S MAIDEN NAME: Hattie Albright

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: none

17. INFORMANT: P.O.Box 599 Address: Cumberland, Md.
Allegany County Infirmary Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardio-vascular disease & advanced
DUE TO: arteric sclerosis.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) DUE TO: Gastric Hemorrhage -
(c)

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1/9/56, 19____ to 9/22/59, 19____, that I last saw the deceased alive on 9/22/59, 19____, and that death occurred at 4:35 P.M., from the causes and on the date stated above

ACTUAL SIGNATURE: L Mathews M.D.
ADDRESS (Street, city or town, state): 49 Greene St. Cumberland, Md.
DATE SIGNED: 9/23/59
PHYSICIAN'S NAME (Type): Dr. L. B. Mathews

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Sept. 25, 1959
22c. NAME OF CEMETERY OR CREMATORY: St. Patricks Cemetery
22d. LOCATION (City town, or county) (State): Mt. Savage, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: John J. Hafer, Cumberland, Maryland

24a. REC'D BY REGISTRAR DATE: SEP 28 59

24b. REGISTRAR'S SIGNATURE: Clifton A. Frame

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09766

CERTIFICATE OF DEATH

09742 Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: [illegible] 22
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Sacred Heart Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
d. STREET ADDRESS: 243 N. Centre St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Emma — Middle: Margaret — Last: Gramlich

4. DATE OF DEATH: Month: 9 — Day: 26 — Year: 1959

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 3-7-1860

9. AGE (In years last birthday): 99 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (State or foreign country): Cumberland, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Richard Bender

14. MOTHER'S MAIDEN NAME: Mary Gesner

15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No,

16. SOCIAL SECURITY NO.: None

INFORMANT: Miss Marie E. Glick — Address: Cumb. Md. 243 N. Centre St.,

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: 2-3 hours
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Cerebral Vascular Accident, right cerebral hemisphere — 3 days
DUE TO
(c) Generalized and Cerebral Arteriosclerosis — years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. **I certify** that I attended the deceased from February 1958 to Sept. 26th, 1959 that I last saw the deceased alive on Sept. 26th, 1959, and that death occurred at 12:45 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Wyand F. Doerner Jr. M.D.
ADDRESS (Street, city or town, state): Algonquin Hotel, Cumberland, Maryland.
DATE SIGNED: 9/27/59
PHYSICIAN'S NAME (Type): Wyand F. Doerner, Jr., M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9/29/59
22c. NAME OF CEMETERY OR CREMATORY: SS. Peter & Paul's
22d. LOCATION (City, town, or county) (State): Cumberland, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: H. Wayne George Cumberland, Maryland

24a. REC'D BY REGISTRAR DATE: SEP 29 '59
24b. REGISTRAR'S SIGNATURE: Clarence L. Friend

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09743

09806 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Oldtown
c. LENGTH OF STAY IN 1b: 1 day
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ellerslie
d. STREET ADDRESS: Gardner Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First KENNETH Middle L. Last GRIFFEY

4. DATE OF DEATH: Month Sept. Day 26 Year 19 59

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: April 27, 1892

9. AGE (In years last birthday): 67 yrs
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret. Carpenter

10b. KIND OF BUSINESS OR INDUSTRY: Rayon factory

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Charles Griffey

14. MOTHER'S MAIDEN NAME: Emma E. Coleman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 214 07 4249

17. INFORMANT: Linwood Griffey Address: Ellerslie, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Coronary Sclerosis

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour ☐ a. m. ☐ p. m. Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

EXAMINER'S NAME (Type): Benedict Skitarelic, M. D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 9/26/59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 9/29/1959

22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

22d. LOCATION (City, town, or county) (State): Cumberland, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Byron Kight ADDRESS: Cumberland, Md.

24a. REC'D BY REGISTRAR DATE: SEP 28 '59

24b. REGISTRAR'S SIGNATURE: Arthur L. Krauss

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME
BM 2/57

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09744

09767

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland,
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Memorial Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland,
d. STREET ADDRESS: 627 Frederick St.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JAMES — Middle EDWARD — Last HARPER
4. DATE OF DEATH: Month Sept. — Day 7, — Year 1959

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: July 31, 1869
9. AGE (In years last birthday): 90 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired wood turner
10b. KIND OF BUSINESS OR INDUSTRY: Lumber business
11. BIRTHPLACE (State or foreign country): Gore, Virginia
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Harper
14. MOTHER'S MAIDEN NAME: Mary F. Light

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No, (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. May H. Minghini — Address: Cumberland, Md. 627 Frederick St.,

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Fracture Rt hip — INTERVAL BETWEEN ONSET AND DEATH: 5 days
DUE TO (b): Infirmities of age and
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
904.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Pneumonia and Uremia
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II as item 18.): Fell in bath room
20c. TIME OF INJURY: Hour 2 a. m. p. m. — Month, Day, Year: 9/3/59
20d. INJURY OCCURRED While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home
20f. (City or town) Cumberland (County) Allegany (State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: R. J. Williams, M.D. — CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒ (acting)
NAME (Type): R. J. Williams M.D.
DATE SIGNED: 9/10/59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9/11/59
22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
22d. LOCATION (City, town, or county): Cumberland, Md. (State)

23. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: Charles L. George Cumberland, Md.
24a. REC'D BY REGISTRAR DATE: SEP 10 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Thomas

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME
BM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09768

CERTIFICATE OF DEATH

09745 Reg. Dist. No

1 PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 7 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address OR INSTITUTION): MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: WEST VIRGINIA
b. COUNTY: MINERAL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RIDGELEY
d. STREET ADDRESS: 172 MAIN ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First EMMA Middle Elizabeth Last HARRISON

4. DATE OF DEATH: Month SEPT. Day 7, Year 19 59

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: JUNE 29, 1886

9. AGE (In years last birthday): 73 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (State or foreign country): MARYLAND, Cumberland U. S. A.

12 CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: EDENHART, CHARLES

14. MOTHER'S MAIDEN NAME: NICKEL, ANNA

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service: No,

16. SOCIAL SECURITY NO.: None

INFORMANT Address: MEMORIAL HOSPITAL CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Ca of stomach — INTERVAL BETWEEN ONSET AND DEATH: 1 year

DUE TO

151X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Pernicious anemia — 8 years

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Terminal cerebral thrombosis — 1 week

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I **certify** that I attended the deceased from 7 - 8 ___, 19 54, to 9 - 7 ___, 19 59, that I last saw the deceased alive on 9 - 7 ___, 19 59, and that death occurred at 10:10 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Ralph L. Ballin, M.D. ADDRESS (Street, city or town, state): 62 Greene St. DATE SIGNED: 9-9-59

PHYSICIAN'S NAME (Type): DR. RALPH BALLIN MD. Cumberland, Md.

22a BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 9/10/59

22c. NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park

22d. LOCATION (City, town, or county) (State): Cumberland, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: H. Wayne George ADDRESS: Cumberland, Md.

24a. REC'D BY REGISTRAR DATE: SEP 14 '59

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/58

X X 1 X

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09769 — Reg. Dist. No. 09746

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Sacred Heart Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
d. STREET ADDRESS: Route 4, Mexico Farms
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ERNEST — Middle E. — Last HARTMAN, JR.
4. DATE OF DEATH: Month Sept. — Day 29, — Year 1959
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Nov. 7, 1922
9. AGE (In years last birthday): 36 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Brakeman
10b. KIND OF BUSINESS OR INDUSTRY: W. M. R. R.
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Ernest E. Hartman, Sr.
14. MOTHER'S MAIDEN NAME: Bertha Beerman
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WW 2
16. SOCIAL SECURITY NO.: 217 18 4865
17. INFORMANT — Address: E. E. Hartman, Sr. Cumberland, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Crushed Chest, Ruptured Liver
DUE TO (b): Automobile Accident
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH: 10-15 Min

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PROBABLY OR CONTRIBUTING CAUSE OF DEATH. ☐
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.): Automobile Accident
20c. TIME OF INJURY — Hour: 4:10 a. m. — Month, Day, Year: Sept. 29 1959
20d. INJURY OCCURRED: While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Rt. #220
20f. (City or town) (County) (State): On Rt. 22, Bedford, Pa.

21. I certify that I took charge of the remains described above, held on Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): Benedict Skitarelic, M. D.
DATE SIGNED: 9/30/1959

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Oct. 2, 1959
22c. NAME OF CEMETERY OR CREMATORY: Davis Memorial Cem.
22d. LOCATION (City, town, or county) (State): Cumberland, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Byron Kight
ADDRESS: Cumberland, Md.
24a. REC'D BY REGISTRAR DATE: OCT 2 '59
24b. REGISTRAR'S SIGNATURE: Clifton E. Kraus
OCT 2 '59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09747

CERTIFICATE OF DEATH

09770 Item 4 file G249 10/5/59 lwk

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: Life.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 511 Riehl Ave

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland Md.
d. STREET ADDRESS: 511 Riehl Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William Middle: G. Last: Helmstetter

4. DATE OF DEATH: Month: Sept. Day: 24 Year: 19 59

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Sept. 28 1876

9. AGE (In years last birthday): 83 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Watchman

10b. KIND OF BUSINESS OR INDUSTRY: B & O.

11. BIRTHPLACE (State or foreign country): Cumberland.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George Helmstetter

14. MOTHER'S MAIDEN NAME: Sabina Rahrig

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No.
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT: Mrs Bertha Imes Address: Cumb. Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Chronic Myocarditis with Decompensation — INTERVAL BETWEEN ONSET AND DEATH: 3 Months
422.2
DUE TO
(b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Hour: o. m. / p. m. Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from ____, 19 50, to 9-24, 19 59, that I last saw the deceased alive on 9-21, 19 59, and that death occurred at 6:00 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: James J. Johnson M.D. — ADDRESS (Street, city or town, state): 16 Greene St Cumberland Md — DATE SIGNED: 9-25-59

PHYSICIAN'S NAME (Type): James J. Johnson Jr 16 Greene St Cumberland, Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 9/28/59

22c. NAME OF CEMETERY OR CREMATORY: SS Peter & Paul Cem.

22d. LOCATION (City, town, or county) (State): Cumberland Md

23. FUNERAL DIRECTOR'S SIGNATURE: Louis Klein Inc. — ADDRESS: Cumb Md

24a. REC'D BY REGISTRAR DATE: SEP 29 '59

24b. REGISTRAR'S SIGNATURE: Clifford A. Thomas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09771

CERTIFICATE OF DEATH

09748
Reg. Dist. No.

1 PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 4 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: MEMORIAL HOSPITAL

2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X CUMBERLAND
d. STREET ADDRESS: RT.#2, Williams Road
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3 NAME OF DECEASED (Type or print): First HERBERT — Middle B. — Last HIGSON

4. DATE OF DEATH: Month SEPTEMBER — Day 7, — Year 19 59

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: MARCH 16, 1912

9. AGE (In years last birthday): 47 yrs.

IF UNDER 1 YEAR: Months | Days — IF UNDER 24 HRS: Hours | Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): STEGMAIER'S FARM

10b. KIND OF BUSINESS OR INDUSTRY: General Farming

11. BIRTHPLACE (State or foreign country): WEST VIRGINIA Keyser

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: HARRY HIGSON

14. MOTHER'S MAIDEN NAME: MAUDE DOUGLING

15. WAS DECEASED EVER IN U. S ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): W.W. 1

16. SOCIAL SECURITY NO: 217-10-1277

INFORMANT: MEMORIAL HOSPITAL- Address: WARWICK & MEMORIAL AVES. CUMBERLAND, MARYLAND.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronal carbon failure
DUE TO (b): Uremia
DUE TO (c): Nephritis

593X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work [ ] Not while at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 9/1/59, 19__ to 9/7/59, 19__ that I last saw the deceased alive on 9/7/59, 19__, and that death occurred at 4:10 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: George M Simons M.D.

ADDRESS (Street, city or town, state): Algonquin Hotel Cumberland Md

DATE SIGNED: 9/11/59

PHYSICIAN'S NAME (Type): DR. G. M. SIMONS

22a BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Sept.10,1959

22c NAME OF CEMETERY OR CREMATORY: Mt. Herman Cemetery

22d LOCATION (City, town, or county) (State): Allegany Co., Maryland

23 FUNERAL DIRECTOR'S SIGNATURE ADDRESS: John J. Hafer, Cumberland, Maryland

24a. REC'D BY REGISTRAR DATE: SEP 11 '59

24b. REGISTRAR'S SIGNATURE: Arthur L Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/58

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09772

09749 Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME SM 2.57

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 50 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
d. STREET ADDRESS: 512 Ridgewood Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First VIRGIL Middle D. Last HINKLE
4. DATE OF DEATH: Month Sept. Day 17, Year 19 59
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Aug. 14, 1897
9. AGE (In years last birthday): 62 yrs
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Weighmaster
10b. KIND OF BUSINESS OR INDUSTRY: Railroad
11. BIRTHPLACE (State or foreign country): Elkins, W. Va.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Philmore H. Hinkle
14. MOTHER'S MAIDEN NAME: Mary Virginia Wentling
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 705 05 8089
17. INFORMANT: Mrs. Juanita McKenzie, Address: Cumberland, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 30 minutes
DUE TO (b): Coronary Artery Disease
DUE TO (c): Arteriosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour 10 a. m. p. m. Month, Day, Year 9/17/59
20d. INJURY OCCURRED: While at work ☒ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) Frank Alley (County) (State) Md

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒ Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: R. J. Williams M.D.
EXAMINER'S NAME (Type)
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒ acting
DATE SIGNED: 9/17/59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Sept. 20, 1959
22c. NAME OF CEMETERY OR CREMATORY: Davis Memorial Cem.
22d. LOCATION (City, town, or county) (State): Cumberland, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Byron Kight
ADDRESS: Cumberland, Md.
24a. REC'D BY REGISTRAR DATE: SEP 21 '59
24b. REGISTRAR'S SIGNATURE: Arthur A. Krause

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09796 **CERTIFICATE OF DEATH** 09750

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg
c. LENGTH OF STAY IN 1b: 4 Months
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Miner's Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg
d. STREET ADDRESS: 66 W. College Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mabel — Middle: L. — Last: Hitchins
4. DATE OF DEATH: Month: September — Day: 19th, — Year: 1959

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: May 17th, 1879
9. AGE (In years last birthday): 80 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired teacher
10b. KIND OF BUSINESS OR INDUSTRY: School Teaching
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John Hitchins
14. MOTHER'S MAIDEN NAME: Sallie Brown

15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: —
INFORMANT: Address: 64 W. College Ave., Mrs. Rachel Dunn, Frostburg, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: Several years
450.0
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 15, 1959 to Sept 19, 1959, that I last saw the deceased alive on Sept 19, 1959, and that death occurred at 10:30 PM, from the causes and on the date stated above.
ACTUAL SIGNATURE: Wm McLane M.D.
ADDRESS (Street, city or town, state): 167 E. Main Street, Frostburg, Md.
DATE SIGNED: Sept 21 1959
PHYSICIAN'S NAME (Type): W. O. McLane

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9-22-59
22c. NAME OF CEMETERY OR CREMATORY: F'bg. Memorial Park,
22d. LOCATION (City, town, or county) (State): Frostburg, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Joseph R. Durst, Frostburg, Md.
24a. REC'D BY REGISTRAR DATE: SEP 23 '59
24b. REGISTRAR'S SIGNATURE: Esther L. Krause

VS A15 (4)
ISM 9/SB

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09751

09773

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland,
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 801 Mann's Terrace

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland.
d. STREET ADDRESS: 801 Mann's Terrace
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ELLA — Middle ISABELLE — Last HOLTZHOUR

4. DATE OF DEATH: Month Sept. — Day 10, — Year 1959

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Nov. 18, 1873

9. AGE (In years last birthday): 85 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (State or foreign country): Sunbury, Penna.

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: John Clymer

14. MOTHER'S MAIDEN NAME: Catherine A. Holter

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown): No, (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mr. Clifton J. Goodrich — Address: 801 Mann's Terrace Cumberland, MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Terminal Coronic Failure — INTERVAL BETWEEN ONSET AND DEATH: 24 hours

443 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Hypertension w/ arteriosclerotic Heart Disease 5 yrs

DUE TO (c): Gen. arteriosclerosis

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 15 June, 1955, to 10 Sept., 1959, that I last saw the deceased alive on 9 Sept., 1959, and that death occurred at 4:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: W. Alfred Van Ormer M.D. — ADDRESS (Street, city or town, state): 122 So. Centre St., Cumberland, Md. — DATE SIGNED: 11 Sept. 59

PHYSICIAN'S NAME (Type): W. A. VanOrmer M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 9/13/59

22c. NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park

22d. LOCATION (City, town, or county) (State): Cumberland, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Charles L. George — ADDRESS: Cumberland, Md.

24a. REC'D BY REGISTRAR DATE: SEP 14 '59

24b REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1

O HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 4

Item 18 Film 248 9-9-59 ams

09774

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 09752

1. PLACE OF DEATH a. COUNTY: ALLEGANY, MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: MARYLAND; b. COUNTY: ALLEGANY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND; c. LENGTH OF STAY IN 1b: 5 hours	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL & MEMORIAL HOSPITAL-WARWICK AVES.	d. STREET ADDRESS: 732 BAKER STREET; e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First BABY, Middle BOY, Last HUFFMAN	4. DATE OF DEATH: Month SEPTEMBER, Day 1, Year 1959
5. SEX: MALE	6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH: AUG. 31, 1959
9. AGE (In years last birthday) yrs; If under 1 year: Months, Days; If under 24 hrs: Hours 5, Min 35	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none	10b. KIND OF BUSINESS OR INDUSTRY: none
11. BIRTHPLACE (State or foreign country): CUMBERLAND, MD.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: BURREL HUFFMAN	14. MOTHER'S MAIDEN NAME: GEORGIA J. ROTRUCK
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): no	16. SOCIAL SECURITY NO: none
INFORMANT (Address): MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND. WARWICK & MEMORIAL AVES.	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Amiotic (parenchyma) [illegible]
DUE TO (b) entire lung parenchyma
DUE TO (c) Patent ductus arteriosus?
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH: 5 hrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Aug 1, 1959 to Sept 1, 1959, that I last saw the deceased alive on Sept 1, 1959, and that death occurred at 2:45 AM from the causes and on the date stated above.

ACTUAL SIGNATURE: W R Hodges M.D.
ADDRESS (Street, city or town, state): Cumberland, Md
DATE SIGNED: 9/1/59

PHYSICIAN'S NAME (Type): DR. HODGES & MOULD.

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	9-1-1959	Huffman Family Cemetery	Flintstone, Md.

23. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS	24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
James F. Scarpelli, Cumberland, Md.	DATE SEP 3 '59	Arthur S Knaak

1

2

1

2060291XV5

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09807 — 09753 Reg. Dist. No.

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH — a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rt. # 1 Cumberland,
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Valley Road

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) — a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rt. # 1 Cumberland,
d. STREET ADDRESS: Valley Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First EMMA — Middle MARIA — Last IMLER
4. DATE OF DEATH: Month Sept. — Day 10, — Year 1959
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Oct. 4, 1863
9. AGE (In years last birthday): 95 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own home
11. BIRTHPLACE (State or foreign country): Bedford Co. Penna.
12. CITIZEN OF WHAT COUNTRY?: U. S. A.
13. FATHER'S NAME: Daniel Dibert
14. MOTHER'S MAIDEN NAME: Maria Croyle
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No, (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT — Address: Mrs. Agnes Hensley, Rt. # 1 Cumberland, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Immediate
DUE TO (b): Arteriosclerosis
DUE TO (c): Ravages of Age
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.): None
20c. TIME OF INJURY — Hour a. m. p. m — Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☑, and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: R. J. Williams M.D.
EXAMINER'S NAME (Type): R. J. Williams M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☑ Actg
DATE SIGNED: 9/10/59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9/12/59
22c. NAME OF CEMETERY OR CREMATORY: Pleasant Valley Cem.
22d. LOCATION (City, town, or county) (State): Nr. Bedford, Penna.
23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Charles L. George Cumberland, Md.
24a. REC'D BY REGISTRAR DATE: SEP 14 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

VS. A15ME 5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09754

09775 **CERTIFICATE OF DEATH** Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 2DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: SACRED HEART HOSPITAL

2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RT. # 5 Cumberland,
d. STREET ADDRESS: Cresap Park
e. IS RESIDENCE ON A FARM? YES ☐ NO XX

3 NAME OF DECEASED (Type or print): First TOLIVER Middle WADE Last JEWELL

4. DATE OF DEATH: Month SEPT. Day 23 Year 19 59

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED XX DIVORCED ☐
8. DATE OF BIRTH: FEB. 13, 1880
9 AGE (n years last birthday): 79 yrs
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS: Hours Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired laborer
10b. KIND OF BUSINESS OR INDUSTRY: Construction
11. BIRTHPLACE (State or foreign country): Rockingham Co. Va.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: EMANUEL JEWELL (DECEASED)
14. MOTHER'S MAIDEN NAME: Susan Zoughlin (DECEASED)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No,
16 SOCIAL SECURITY NO.: 217-10-6677
INFORMANT: Mr, Lester L. Jewell Address: 937 Md. Ave., Cumb. Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): arteriosclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH: 1 year
DUE TO
420.0
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Generalized arteriosclerosis — 2 years
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY Hour a. m. p. m. Month Day Year 19
20d INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 4-3- 19 57 to 9-23 19 57, that I last saw the deceased alive on 9-23 19 57, and that death occurred at 11:00 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Lewis Brings M.D. — ADDRESS (Street, city or town, state): 55 GREENE S., CUMBERLAND, MARYLAND — DATE SIGNED: 9-25-59

PHYSICIAN'S NAME (Type): Lewis Brings, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9/26/59
22c NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park
22d. LOCATION (City, town, or county) (State): Cumberland, Maryland

23 FUNERAL DIRECTOR'S SIGNATURE: H. Wayne George ADDRESS: Cumberland, Md.
24a REC'D BY REGISTRAR DATE: SEP 28 '59
24b. REGISTRAR'S SIGNATURE: Clothus E. Hann

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09776 — 09755 — Reg. Dist. No.

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designate agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AISME 5M 2/57

1. PLACE OF DEATH — a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 35yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): I804 Oldtown Road

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) — a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
d. STREET ADDRESS: I804 Oldtown Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Effie — Middle: Caroline — Last: Kellar
4. DATE OF DEATH: Month: Sept. — Day: 7, — Year: 1959
5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH: Dec. I7, I886
9. AGE (In years last birthday): 72 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Salem, W.Va.
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Geo. A. Davis
14. MOTHER'S MAIDEN NAME: Melvina Boyce

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Beryl E. Kellar — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 8 hrs
DUE TO (b): Coronary Sclerosis
DUE TO (c): —
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): —
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.): —
20c. TIME OF INJURY: Hour: — o. m. p. m. — Month, Day, Year: — 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): —
20f. (City or town) (County) (State): —

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: R J Williams M.D
EXAMINER'S NAME (Type): Richard J. Williams, MD
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒ (acting)
DATE SIGNED: 9/2/59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9-10-1959
22c. NAME OF CEMETERY OR CREMATORY: Zion Memorial Park
22d. LOCATION (City, town, or county) (State): Cumberland, Md.

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: James F. Scarpelli, Cumberland, Md.
24a. REC'D BY REGISTRAR DATE: SEP 10 '59
24b. REGISTRAR'S SIGNATURE: Carlton L. Kuhn

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09808 **CERTIFICATE OF DEATH** 09756

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): La Vale -Rural
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Route # 40

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 ~~Barto~~ Cumberland
d. STREET ADDRESS: 820 Oldtown Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Robert Middle: Keith Last: Kelley
4. DATE OF DEATH: Month: Sept Day: 13 Year: 1959
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Jan. 1, 1901
9. AGE (In years last birthday): 58 yrs. IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS: Hours: Min:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk
10b. KIND OF BUSINESS OR INDUSTRY: Paper Mill
11. BIRTHPLACE (State or foreign country): Beryl, W.Va.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Archibald Kelley
14. MOTHER'S MAIDEN NAME: Sarah Scott
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 216-07-8871
INFORMANT: Address: Bessie Kelley-Cumberland, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a): Coronary Thrombosis
DUE TO (b): Coronary artery disease
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH: Sudden

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour: o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from 5-24-, 1959, to 9-13-, 1959, that I last saw the deceased alive on 5-7-, 1959, and that death occurred at 11:30 a.m. from the causes and on the date stated above.

ACTUAL SIGNATURE: Wm. F. Williams M.D. ADDRESS (Street, city or town, state): Cumberland Md. DATE SIGNED: 9-15-59

PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9/16/59
22c. NAME OF CEMETERY OR CREMATORY: Hillcrest
22d. LOCATION (City, town, or county) (State): Cumberland Md.

23. FUNERAL DIRECTOR'S SIGNATURE: E. L. Rural ADDRESS: Westernport, Md.
24a. REC'D BY REGISTRAR DATE: SEP 17 '59
24b. REGISTRAR'S SIGNATURE: Wilbur A. Krantz

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09777

CERTIFICATE OF DEATH

09757 Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 3/16/59
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Allegany County Infirmary

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland,
d. STREET ADDRESS: 328 Fayette St.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Clara — Middle: Lillian — Last: Kerber

4. DATE OF DEATH: Month: September — Day: 10, — Year: 1959

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 10/11/1873

9. AGE (In years last birthday): 85 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (State or foreign country): Frostburg, Maryland

12. CITIZEN OF WHAT COUNTRY: U. S. A.

13. FATHER'S NAME: William Beane

14. MOTHER'S MAIDEN NAME: Kathryn Brennan

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No,

16. SOCIAL SECURITY NO: None

17. INFORMANT: P.O.Box 599 Address: Cumberland, Md.
Allegany County Infirmary Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Pulmonary Hypostasis. — INTERVAL BETWEEN ONSET AND DEATH: 36 hrs.

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 422.1

(b) Chronic Myocardial Degeneration — ?

DUE TO

(c) General arteriosclerosis. — ?

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Osteo arthritis.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from 3/16/59, 19____, to 9/10/59, 19____, that I last saw the deceased alive on 9/10/59, 19____, and that death occurred at 7:05 P.M. from the causes and on the date stated above

ACTUAL SIGNATURE: James E. McLean M.D — ADDRESS (Street, city or town, state): 49 Greene St. — DATE SIGNED: 9/11/59

PHYSICIAN'S NAME (Type): Dr. James E. McLean — Cumberland, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 9/12/59

22c NAME OF CEMETERY OR CREMATORY: SS. Peter & Paul's

22d LOCATION (City, town, or county) (State): Cumberland, Maryland

23 FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Charles L. George Cumberland, Md.

24a. REC'D BY REGISTRAR DATE: SEP 14 '59

24b. REGISTRAR'S SIGNATURE: Arthur L Kuhn

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09797

CERTIFICATE OF DEATH

09758
Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

VS A1S (4)
1SM 9/SB

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg,
c. LENGTH OF STAY IN 1b: 25 Yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 54 Ormand Street

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg
d. STREET ADDRESS: 54 Ormand Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Joseph — Middle: T. — Last: Kidwell

4. DATE OF DEATH: Month: Sept. — Day: 18th, — Year: 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 10th, 1911

9. AGE (In years last birthday): 48 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Foreman-Spinning

10b. KIND OF BUSINESS OR INDUSTRY: Celanese Corp.

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Kidwell

14. MOTHER'S MAIDEN NAME: Janet Gracie

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 214-07-5355

INFORMANT: Mrs. Margaret Kidwell, Address 54 Ormand St., Frostburg, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): acute Myocardial Dilation — INTERVAL BETWEEN ONSET AND DEATH: 20 min

DUE TO (b): Coronary Embolism — ?

DUE TO (c):

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: — a. m. p. m. — Month, Day, Year: 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Sept 18, 1959 to Sept 18, 1959 that I last saw the deceased alive on Sept 18, 1959, and that death occurred at 6:30 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: W.M.C. Lane M.D.

ADDRESS (Street, City or town, state): Frostburg

DATE SIGNED: Sept 18 59

PHYSICIAN'S NAME (Type): W.M.C. Lane M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 9-21-59

22c. NAME OF CEMETERY OR CREMATORY: F'bg. Memorial Park

22d. LOCATION (City, town, or county) (State): Frostburg, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Joseph R. Durst, Frostburg, Md.

24a. REC'D BY REGISTRAR DATE: SEP 21 '59

24b. REGISTRAR'S SIGNATURE: Arthur J. Krantz

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09778

CERTIFICATE OF DEATH

09759
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 19 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR NAME: MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
d. STREET ADDRESS: 120 LAING AVENUE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: RACHEL — Middle: C. — Last: KROWE
4. DATE OF DEATH: Month: SEPT. — Day: 17 — Year: 1959
5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: NOVEMBER 13, 1876
9. AGE (In years last birthday): 82 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housekeeper
10b. KIND OF BUSINESS OR INDUSTRY: At Home
11. BIRTHPLACE (State or foreign country): WEST VIRGINIA
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: HENRY SIMONS
14. MOTHER'S MAIDEN NAME: SARA SIMONS
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.:
INFORMANT: MEMORIAL HOSPITAL — Address: CUMBERLAND, MARYLAND

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Uraemia — INTERVAL BETWEEN ONSET AND DEATH: 1 wk
DUE TO (b): Chronic Congestive Failure — 2 mos
DUE TO (c): Generalized Arteriosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 450.0

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from 9-13, 19__, to 9-17, 1959 that I last saw the deceased alive on 9-17-59, 19__, and that death occurred at 3:40P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: William R. Jones, M.D. — ADDRESS (Street, city or town, state): 441 4 Center St — DATE SIGNED: 9-19-59
PHYSICIAN'S NAME (Type): William R Jones DR. OVERTON HIMMELWRIGHT — Cumberland Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9/20/59
22c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park
22d. LOCATION (City, town, or county) (State): Cumberland Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Ruth E. Silcox — ADDRESS: Cumberland Maryland
24a. REC'D BY REGISTRAR DATE: SEP 24 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Kime

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09779

CERTIFICATE OF DEATH

09760 Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Sacred Heart Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: W.VA. b. COUNTY: Mineral
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ridgeley,
d. STREET ADDRESS: 12 Jones St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Regina Middle Lucille Last Lechliter
4. DATE OF DEATH: Month Sept. Day 20, Year 1959

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Oct. 30,-1943
9. AGE (In years last birthday): 15 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own home
11. BIRTHPLACE (State or foreign country): Cumberland, Maryland
12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George D. Shaffer
14. MOTHER'S MAIDEN NAME: Mary Jones

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No, (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
INFORMANT: Mr. John L. Lechliter Address: 12 Jones St., Ridgeley, W.Va

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Serum Hepatitis — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
751X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 7/15, 1959, to 9/20, 1959, that I last saw the deceased alive on 9/20, 1959, and that death occurred at 4:50 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Leo H. Ley Jr M.D. ADDRESS (Street, city or town, state): 452 N. Centre St Cumberland, Md. DATE SIGNED: 9/21/59
PHYSICIAN'S NAME (Type): Dr. Leo H. Ley

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9/23/59
22c. NAME OF CEMETERY OR CREMATORY: Zion Memorial Cem.
22d. LOCATION (City, town, or county) (State): Cumberland, Maryland

23 FUNERAL DIRECTOR'S SIGNATURE: Charles L. George ADDRESS: Cumberland, Md.
24a. REGISTERED BY REGISTRAR DATE: SEP 24 59
24b. REGISTRAR'S SIGNATURE: Clifton A. Kinna

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09798

CERTIFICATE OF DEATH

09761
Reg. Dist. No.

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1. PLACE OF DEATH a. COUNTY: ALLEGANY — MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE: MARYLAND b. COUNTY: ALLEGANY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FROSTBURG c. LENGTH OF STAY IN 1b: 70 Yrs.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FROSTBURG
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 42 LINDEN ST.	d. STREET ADDRESS: 42 LINDEN ST. e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
MARION	G.	LEWIS	SEPT.	25,	19 59

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS Hours / Min
FEMALE	WHITE		JAN. 10, 1866	93 yrs		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
HOUSEWORK	OWN HOME	WALES	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
DAVID GRIFFITH	MARY YATES

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown. If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	INFORMANT Address
	NONE	GRIFFITH LEWIS, FROSTBURG, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uterine Sclerosis — INTERVAL BETWEEN ONSET AND DEATH: 3 years

DUE TO (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

4500

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)

21. I certify that I attended the deceased from 1956, 19___, to Sept 25, 1959, that I last saw the deceased alive on Sept 20, 1959, and that death occurred at 7:15 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: W O McLane M.D.

ADDRESS (Street, city or town, state): E. MAIN ST., FROSTBURG, MD.

DATE SIGNED: Sept 26 1959

PHYSICIAN'S NAME (Type): W. O. McLANE, M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
BURIAL	SEPT. 28 '59	F'BG. MEMORIAL PARK	FROSTBURG, MD.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
J. R. DURST, FROSTBURG, MD.	SEP 28 '59	Arthur L Frame

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09762

09780

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 10/57

1. PLACE OF DEATH a. COUNTY: Allegany — MARYLAND	2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE: Maryland b. COUNTY: Allegany
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland — c. LENGTH OF STAY IN 1b: Lifetime	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 608 Columbia Avenue	d. STREET ADDRESS: 608 Columbia Ave. — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)	First: Mollie	Middle:	Last: Maihl	4. DATE OF DEATH	Month: Sept.	Day: 24	Year: 1959	
5. SEX: Female	6. COLOR OR RACE: White	7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH: Aug. 20, 1874	9. AGE (In years last birthday): 85 yrs	IF UNDER 1 YEAR Months:	Days:	IF UNDER 24 HRS Hours:	Min:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Seamstress	10b. KIND OF BUSINESS OR INDUSTRY: Self Employed	11. BIRTHPLACE (State or foreign country): Cumberland, Md.	12 CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: John Maihl		14. MOTHER'S MAIDEN NAME: Margaret Dietrich	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service): no	16. SOCIAL SECURITY NO.	17 INFORMANT Address: Miss Mamie Dietrich, Cumberland, Md.	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Anemia — INTERVAL BETWEEN ONSET AND DEATH: 6 months

DUE TO (b): Intermittent Fever — 10 yrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 150.0 — DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	

21. I certify that I attended the deceased from June, 1959 to Sept 24, 1959 that I last saw the deceased alive on Sept. 22, 1959, and that death occurred at 11:35 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Clay E. Durrett M.D. — ADDRESS (Street, city or town, state): 236 Virginia Ave. — DATE SIGNED: 9-25-1959

PHYSICIAN'S NAME (Type): Clay E. Durrett, MD — Cumberland, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial	22b. DATE THEREOF: 9-29-1959	22c NAME OF CEMETERY OR CREMATORY: SS. Peter & Paul Cemetery	22d. LOCATION (City, town, or county) (State): Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: James F. Scarrelli, Cumberland, Md.		24a REC'D BY REGISTRAR DATE: SEP 29 '59	24b REGISTRAR'S SIGNATURE: Arthur L. Kraus	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09781 **CERTIFICATE OF DEATH** 09763

Reg. Dist. No.

1 PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland,
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 513 Rose Hill Ave.,

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland,
d. STREET ADDRESS: 513 Rose Hill Ave.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First MAUDE — Middle ESSIE — Last MATHEWS

4. DATE OF DEATH: Month Sept. — Day 24, — Year 1959

5 SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Oct. 10, 1893

9 AGE (In years last birthday): 65 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (State or foreign country): Sharpsburg, Md.

12 CITIZEN OF WHAT COUNTRY: U. S. A.

13. FATHER'S NAME: Emory D. Gray

14. MOTHER'S MAIDEN NAME: Fannie M. Benner

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No,

16. SOCIAL SECURITY NO: None

17 INFORMANT: Mrs. Myrtle Brode — Address: 511 Rose Hill Ave., Cumberland, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a): Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH: 6 Months

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 181.0

(b) Carcinoma of Urinary Bladder — 18 Months

DUE TO

(c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour, a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Aug. 31, 1959, to Sept. 24, 1959, that I last saw the deceased alive on Sept. 24, 1959, and that death occurred at 7:55 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: L. Michael Glick, M.D. — ADDRESS (Street, city or town, state): 126 N. Smallwood St., Cumberland, Md. — DATE SIGNED: 25 Sept 59

PHYSICIAN'S NAME (Type): L. Michael Glick, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 9/27/59

22c NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park

22d. LOCATION (City, town, or county) (State): Cumberland, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: H. Wayne George — ADDRESS: Cumberland, Maryland

24a. REC'D BY REGISTRAR DATE: SEP 28 '59

24b REGISTRAR'S SIGNATURE: Arthur L. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09764

09782

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 20 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): NIKEP
d STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First SAMUEL — Middle — Last MC CUTCHEON

4. DATE OF DEATH: Month SEPTEMBER — Day 3 — Year 1959

5 SEX: MALE

6. COLOR OR RACE: WHITE

7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: MAY 17 1884

9 AGE (In years last birthday): 75 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Coal Miner

10b. KIND OF BUSINESS OR INDUSTRY:

11 BIRTHPLACE (State or foreign country): MARYLAND

12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: SAMUEL MC CUTCHEON

14. MOTHER'S MAIDEN NAME: FANNY JACOBS

15 WAS DECEASED EVER IN U. S ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

INFORMANT: MEMORIAL HOSPITAL — Address: CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebro-Vascular Accident (Embolus) — INTERVAL BETWEEN ONSET AND DEATH: Immediate
DUE TO
4 a 0.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Aricular Fibrillation — ??
DUE TO
(c) Coronary Arteriosclerosis; Myocardial Fibrosis — ??

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Had Cerebro Vascular Accident (embolus) August 14, 1959

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) Cumberland, (County) (State) Maryland

21. I certify that I attended the deceased from August 14 1959, to September 3 1959, that I last saw the deceased alive on September 3 1959, and that death occurred at 11:40 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D. — ADDRESS (Street, city or town, state): 50 Pershing Street — DATE SIGNED: 9/4/59

PHYSICIAN'S NAME (Type): S. G. MEGHAN for S. M. JACOBSON — Cumberland, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b DATE THEREOF: 9.6.1959
22c NAME OF CEMETERY OR CREMATORY: Laurel Hill Cemetery
22d LOCATION (City, town, or county) (State): Moscow, MD.

23. FUNERAL DIRECTOR'S SIGNATURE: GEORGE EICHHORN — ADDRESS: LONACONING, MD.

24a RECD BY REGISTRAR DATE: SEP 8 59

24b REGISTRAR'S SIGNATURE: Clifton L. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09765

09799 **CERTIFICATE OF DEATH**

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Miners Hospital

2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
X c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): "Rural" Frostburg
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William — Middle: — Last: McNeil

4. DATE OF DEATH: Month: September — Day: 14 — Year: 19 59

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: November 8, 1873

9. AGE (In years last birthday): 85 yrs

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Hampshire, W.Va

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William McNeil

14. MOTHER'S MAIDEN NAME: Elizabeth O'Neil

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 24-07-4[illegible]

17. INFORMANT: Leo McNeil — Address: Klondike, Maryland "Brother"

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac Failure — INTERVAL BETWEEN ONSET AND DEATH: 2 wks.
DUE TO (b): Cardiovascular Renal Disease — 2 months
DUE TO (c): Partial Gastric obstruction

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year; Hour a. m. p. m.; 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Feb. 19 58 to Sept. 14 19 59 that I last saw the deceased alive on Sept 14 19 59, and that death occurred at 4:25 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: John B. Davis, M.D. — ADDRESS (Street, city or town, state): 2 Broadway — DATE SIGNED: 9/14/59

PHYSICIAN'S NAME (Type): John B. Davis, MD — Frostburg, md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 9/16/59

22c. NAME OF CEMETERY OR CREMATORY: Memorial Park

22d. LOCATION (City, town, or county) (State): Frostburg, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: George Eichhorn — ADDRESS: Lonaconing, Maryland

24a. REC'D BY REGISTRAR DATE: SEP 17 '59

24b. REGISTRAR'S SIGNATURE: Clifton E. Kinna

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09783

CERTIFICATE OF DEATH

09766 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: ONE DAY
d. NAME OF HOSPITAL (If not in hospital, give street address OR INSTITUTION): MEMORIAL HOSPITAL WARWICK & MEMORIAL AVES.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X CUMBERLAND, MD.
d. STREET ADDRESS: RT. # 1 BOWMAN'S ADDITION
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MICHAEL Middle QLIN Last MILLER

4. DATE OF DEATH: Month SEPTEMBER Day 7, Year 19 59

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: JUNE 30, 1952

9. AGE (In years last birthday) 7 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS: Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): CUMBERLAND, MD.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: MILLER, ROBERT O.

14. MOTHER'S MAIDEN NAME: TUCKER, RUTH LEE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. None

INFORMANT Address: MEMORIAL HOSPITAL -CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bulbar Polio — INTERVAL BETWEEN ONSET AND DEATH 18 hours

DUE TO

080.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b)

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Sept 5, 19 57 to Sept 7, 19 57, that I last saw the deceased alive on Sept 7, 19 57, and that death occurred at 6:00PM, from the causes and an the date stated above.

ACTUAL SIGNATURE: H. Himmelwright M.D. ADDRESS (Street, city or town, state): 133 Virginia Ave Cumberland, Md. DATE SIGNED: 9/9/57

PHYSICIAN'S NAME (Type): DR. OVERTON G. HIMMELWRIGHT

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 9-9-59

22c. NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park

22d. LOCATION (City, town, or county) (State): Cumberland, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: James F. Scarpelli ADDRESS: Cumberland, Md.

24a. REC'D BY REGISTRAR DATE: SEP 14 '59

24b. REGISTRAR'S SIGNATURE: Curtis L. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please mail or deliver it to the registrar. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/58

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09809 — Reg. Dist. No. 09767

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural, near Cumberland
c. LENGTH OF STAY IN 1b: 3 mos
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Route 4, Willowbfook Road

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural, near Cumberland
d. STREET ADDRESS: Route 4, Willowbrook Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CHARLES Middle MAXWELL Last MITCHELL

4. DATE OF DEATH: Month September Day 14 Year 19 59

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Nov. 3, 1932

9. AGE (In years last birthday): 26 yrs.

IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS: Hours ___ Min ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Textile Wkr.

10b. KIND OF BUSINESS OR INDUSTRY: Celanese Corp. of America

11. BIRTHPLACE (State or foreign country): Cumberland, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Thomas M. Mitchell

14. MOTHER'S MAIDEN NAME: Mary Davis

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): yes (If yes, give war or dates of service): Korean Conflict

16. SOCIAL SECURITY NO: 215-26-9892

17. INFORMANT: Mrs. Mary Davis Mitchell Address: Rt. 4 Cumberland, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Shotgun Cranial Damage — INTERVAL BETWEEN ONSET AND DEATH: almost at

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): by gun shot wound
DUE TO (c): —

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): —

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18): Gun shot wound head

20c. TIME OF INJURY: Hour 1:30 a.m. p.m. Month, Day, Year 9/14/59

20d. INJURY OCCURRED: While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home

20f. (City or town) (County) (State): Cumb Alleg Md

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: R J Williams M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒ acting
EXAMINER'S NAME (Type): Richard J. Williams
DATE SIGNED: Sept. 15, 1959

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 9/19/59

22c. NAME OF CEMETERY OR CREMATORY: Sunset Mem. Park

22d. LOCATION (City, town, or county) (State): Cumberland, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: John J. Hafer, Cumberland, Maryland

24a. REC'D BY REGISTRAR: DATE SEP 17 '59

24b. REGISTRAR'S SIGNATURE: Carlton L. Kraus

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09810

CERTIFICATE OF DEATH

09768
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Lonaconing
c. LENGTH OF STAY IN 1b: 78yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Castle Street

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Lonaconing
d. STREET ADDRESS: Castle Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First CHARLES Middle KINGSLEY Last MORGAN
4. DATE OF DEATH: Month 9/13/1959 Day Year 19
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 10/31/1880
9. AGE (In years last birthday): 78 yrs
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Pipefitter
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Lonaconing, MD.
12 CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Essau Morgan
14. MOTHER'S MAIDEN NAME: Rebecca Rinker
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO: 216-07-2720
17 INFORMANT Address: Mrs. Nellie Morgan, Lonaconing, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion, massive (WIFE)
DUE TO (b): Arteriosclerosis
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
420.1
INTERVAL BETWEEN ONSET AND DEATH: Years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Congestive Heart Failure
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Dec. 1955, to Sept 1959, that I last saw the deceased alive on Sept. 3, 1959, and that death occurred at 1 a.m., from the causes and on the date stated above.

ACTUAL SIGNATURE: Leslie R. Miles Jr. M.D.
ADDRESS (Street, city or town, state):
DATE SIGNED: 9.14.59

PHYSICIAN'S NAME (Type): LESLIE R. MILES, JR. M.D. LONACONING MD

22a BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9/15/1959
22c NAME OF CEMETERY OR CREMATORY: Oak Hill Cemetery
22d. LOCATION (City, town, or county) (State): Lonaconing, MD.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: GEORGE EICHHORN LONACONING? MD.
24a. REC'D BY REGISTRAR DATE: SEP 15 '59
24b. REGISTRAR'S SIGNATURE: Clifton S. Kramer

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M

I

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09800

CERTIFICATE OF DEATH

09769

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg
c. LENGTH OF STAY IN 1b: 6 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Miner's Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Eckhart
d. STREET ADDRESS: /
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mae — Middle: Desmond — Last: Muir

4. DATE OF DEATH: Month: September — Day: 28th, — Year: 19 59

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Jan. 10th, 1886

9. AGE (In years last birthday): 73 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: own housework

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Willison

14. MOTHER'S MAIDEN NAME: Agnes Walkinshaw

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 214-05-9925

INFORMANT: Melvin Muir, — Address: Eckhart, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral accident — INTERVAL BETWEEN ONSET AND DEATH: 3 Weeks

4-2-1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Arteriosclerotic Cardio-vascular disease — Years

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 19 47 to September 28 19 59 that I last saw the deceased alive on September 19 59, and that death occurred at 2:15 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: John B. Davis, M.D. — ADDRESS (Street, city or town, state): 2 Broadway, — DATE SIGNED

PHYSICIAN'S NAME (Type): John B. Davis — " Frostburg, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Oct. 1st, 59

22c. NAME OF CEMETERY OR CREMATORY: Eckhart Cemetery

22d. LOCATION (City, town, or county) (State): Eckhart, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Joseph R. Durst, Frostburg, Md.

24a. REC'D BY REGISTRAR DATE: OCT 2 '59

24b. REGISTRAR'S SIGNATURE: Arthur A. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09784 — 09770 Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH — a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 1 day
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Sacred Heart Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) — a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 22 Cumberland
d. STREET ADDRESS: 717 North Mechanic Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: John — Middle: Raphael — Last: Nee
4. DATE OF DEATH: Month: September — Day: 20 — Year: 1959
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Sept. 20, 1900
9. AGE (In years last birthday): 59 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Brewery worker
10b. KIND OF BUSINESS OR INDUSTRY: Cumberland Brewery
11. BIRTHPLACE (State or Foreign country): Cumberland, Maryland
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: John Stephen Nee
14. MOTHER'S MAIDEN NAME: Lucy O'Donnell
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 214-05-4830
17. INFORMANT: Mrs. Dorothy Nee Address 717 N. Mechanic Street Cumberland, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Insufficiency and Occlusion, Marked — INTERVAL BETWEEN ONSET AND DEATH: years...
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b): Arteriosclerosis
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Occlusion of Iliac vessels due to atheromatous material. Died in Surgery.
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☒ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.): Automobile accident
20c. TIME OF INJURY — Hour: 10:00 a.m. p.m. — Month, Day, Year: Sept. 19 1959
20d. INJURY OCCURRED — White at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Rt. #40
20f. (City or town) Town Hill (County) Alleg. (State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Benedict Skitarelic M.D. — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒ — DATE SIGNED: Sept. 20, 1959
EXAMINER'S NAME (Type): Benedict Skitarelic, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Sept. 23, 1959
22c. NAME OF CEMETERY OR CREMATORY: St. Peter & Pauls Cem
22d. LOCATION (City, town, or county) (State): Cumberland, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: John J. Hafer, Cumberland, Maryland
24a. REC'D BY REGISTRAR — DATE: SEP 23 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2. See: birth Cert. et

09771

09801

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Miners Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: Garrett
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Avilton
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Baby — Middle: — Last: Parr

4. DATE OF DEATH: Month: Sept — Day: 5 — Year: 1959

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Sept 5 1959

9. AGE (If years last birthday) yrs. — IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: 1 — Min.: 47

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Frostburg Md

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Sammie Parr

14. MOTHER'S MAIDEN NAME: Mary Jane Peterson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO:

INFORMANT: Mary Jane Parr — Address: Avilton Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Prematurity — Congenital Malformation of Abdomen — INTERVAL BETWEEN ONSET AND DEATH: 1 hr 6 Min.

DUE TO (b):

DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour: o. m. / p. m. Month: Day: Year: 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Sept 5, 1959, to Sept 5, 1959, that I last saw the deceased alive on Sept 5, 1959, and that death occurred at 1:13 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Wm C Lane MD — ADDRESS (Street, city or town, state): Frostburg Md — DATE SIGNED: Sept 5 1959

PHYSICIAN'S NAME (Type): Wm C Lane MD

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: 9/7/59 — 22c. NAME OF CEMETERY OR CREMATORY: New Germany — 22d. LOCATION (City, town, or county): Rural Grantsville (State): MD

23. FUNERAL DIRECTOR'S SIGNATURE: Leo Mumma — ADDRESS: Grantsville Md

24a. RECD BY REGISTRAR DATE: SEP 9 '59 — 24b. REGISTRAR'S SIGNATURE: Arthur S Kline

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

20 6 128 3 X U 3

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09785

09773

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1. PLACE OF DEATH a. COUNTY: ALLEGANY	MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: MARYLAND	b. COUNTY: ALLEGANY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND	c. LENGTH OF STAY IN 1b: 6 DAYS	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,		d. STREET ADDRESS: 107 MARY ST.,	e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First SUSAN	Middle	Last PRYOR	4. DATE OF DEATH: Month SEPTEMBER	Day	Year 1959			
5. SEX: FEMALE	6. COLOR OR RACE: WHITE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH: FEB. 24	9. AGE (In years last birthday) 81 yrs.	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife	10b. KIND OF BUSINESS OR INDUSTRY: Home	11. BIRTHPLACE (State or foreign country): CUMBERLAND, MARYLAND	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: THOMAS BRIDENTHAWAL		14. MOTHER'S MAIDEN NAME: HESTER ANN PRICE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. None.	INFORMANT: MEMORIAL HOSPITAL	Address: CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Carcinoma of liver — INTERVAL BETWEEN ONSET AND DEATH: 6 months

156.1

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a). 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town)	(County) (State)

21. I certify that I attended the deceased from Jan, 19 59, to Aug, 19 59 that I last saw the deceased alive on Aug 31, 19 59, and that death occurred at 8:30 AM from the causes and on the date stated above.

ACTUAL SIGNATURE: G. Himmelwright M.D. ADDRESS (Street, city or town, state): 133½ Ave, Cumberland, Md DATE SIGNED: 9/1/59

PHYSICIAN'S NAME (Type): G. OVERTON HIMMELWRIGHT

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial	22b. DATE THEREOF: 9/3/59	22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cem.	22d. LOCATION (City, town, or county): Cumberland	(State) Md.
23. FUNERAL DIRECTOR'S SIGNATURE: Louis Stein Inc.	ADDRESS: Cumb. Md	24a. REC'D BY REGISTRAR DATE: SEP 8 '59	24b. REGISTRAR'S SIGNATURE: Arthur S Kness	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

0981 — 03774 — Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Maryland Route 55
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RD 2, Frostburg
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Frederick — Middle: J. — Last: Rankin
4. DATE OF DEATH: Month: September — Day: 17th, — Year: 19 59
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Sept. 16th, 1927
9. AGE (In years last birthday): 32 yrs. — IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Bartender
10b. KIND OF BUSINESS OR INDUSTRY: Moose Home
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: James Rankin
14. MOTHER'S MAIDEN NAME: Mabel Gordon
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): W.W. 2
16. SOCIAL SECURITY NO.: 212-24-0219
17. INFORMANT: Mrs. Mabel Rankin — Address: BOX 183, RFD 2, Frostburg, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Fractured Skull - Frac. Left leg — INTERVAL BETWEEN ONSET AND DEATH: Unknown
DUE TO (b): Laceration of face & body
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): —

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): auto accident struck rear by [illegible] and overturned
20c. TIME OF INJURY: Hour 6:15 p. m. — Month, Day, Year: 9/17/59
20d. INJURY OCCURRED: While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Rt 55
20f. (City or town) (County) (State): Near Vale Summit Allegany Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: R. J. Williams — M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒ acting
DATE SIGNED: 9/17/59
NAME (Type): R. J. Williams

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9-20-59
22c. NAME OF CEMETERY OR CREMATORY: Porter Cemetery
22d. LOCATION (City, town, or county) (State): Eckhart, Md.

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Joseph R. Durst, Frostburg, Md.
24a. REC'D BY REGISTRAR DATE: SEP 21 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

09786

09775 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: ALLEGANY
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 2 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 CUMBERLAND
d. STREET ADDRESS: WASHINGTON & LEE APTS., LEE STREET
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JOHN Middle JOSEPH Last REINHARD
4. DATE OF DEATH: Month SEPTEMBER Day 3 Year 1959
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: APRIL 19, 1886
9. AGE (In years last birthday): 73 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS: Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED PEPSI
10b. KIND OF BUSINESS OR INDUSTRY: COLA BOTTLING CO.
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: GEORGE A. REINHARD
14. MOTHER'S MAIDEN NAME: ANNA LONG

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
INFORMANT: MEMORIAL HOSPITAL Address: WARWICK & MEMORIAL AVENUE, CUMBERLAND, MARYLAND

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)	Cerebral Hemorrhage with left hemiplegia	9 hours
DUE TO (b)	Congestive Heart Failure	3 days
DUE TO (c)	arteriosclerotic Cardiovascular Disease	3 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes Mellitus - Hyp. arteriosclerosis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1 Jan., 1959, to 3 Sept., 1959, that I last saw the deceased alive on 3 Sept., 1959, and that death occurred at 11:07 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: W. Alfred Van Ormer M.D.
ADDRESS (Street, city or town, state): 122 S. Centre St. Cumberland, Md.
DATE SIGNED: 4 Sept. 59
PHYSICIAN'S NAME (Type): DR. W. A. VAN ORMER

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9/7/59
22c. NAME OF CEMETERY OR CREMATORY: St. Peter & Paul.
22d. LOCATION (City, town, or county) (State): Cumberland Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Louis Stein Inc.
ADDRESS: Cumb. Md
24a. REC'D BY REGISTRAR DATE: SEP 9 '59
24b. REGISTRAR'S SIGNATURE: Clifton L. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09787

CERTIFICATE OF DEATH

09777
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 5 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Sacred Heart Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Dansville
d. STREET ADDRESS: Rural
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Leonard — Middle: Wm — Last: Robertson

4. DATE OF DEATH: Month: Sept. — Day: 18 — Year: 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 3/13/14

9. AGE (In years last birthday): 45 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Harrison Robertson

14. MOTHER'S MAIDEN NAME: Laura Gracie

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WW #2

16. SOCIAL SECURITY NO.: 233-44-5539

INFORMANT: Pt's chart. — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 5 days
DUE TO (b): Generalized arteriosclerosis — 1 year
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from May ..., 1959, to Sept. 18, 1959, that I last saw the deceased alive on Sept. 14, 1959, and that death occurred at ...M, from the causes and on the date stated above.

ACTUAL SIGNATURE: B. M. Schindler M.D. — ADDRESS (Street, city or town, state): 43 Emmett Cumberland Md — DATE SIGNED: 9-19-59

PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Sept. 20, 1959
22c. NAME OF CEMETERY OR CREMATORY: Waxler
22d. LOCATION (City, town, or county) (State): Danville, Md

23. FUNERAL DIRECTOR'S SIGNATURE: Rogers Funeral Home — ADDRESS: Keyser W. Va.

24a. REC'D BY REGISTRAR DATE: SEP 23 '59
24b. REGISTRAR'S SIGNATURE: Arthur A. Frame

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIR[illegible]R: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/SB

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09778 Reg. Dist. No.

09812

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Maryland Route 55
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 12 Frostburg
d. STREET ADDRESS: 118 McCulloh St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Robert — Middle: D. — Last: Seifarth
4. DATE OF DEATH: Month: September — Day: 17th, — Year: 1959

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: March 30th, 1919
9. AGE (In years last birthday): 40 yrs.
IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Steel Const. Worker
10b. KIND OF BUSINESS OR INDUSTRY: Bl'dg. Constr.
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Andrew Seifarth
14. MOTHER'S MAIDEN NAME: Ruth Walsh

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO: 215-14-6373
17. INFORMANT: Mrs. Edith C. Seifarth, Address 118 McCulloh St., Frostburg, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Fracture both legs, side of — INTERVAL BETWEEN ONSET AND DEATH: Immediate
DUE TO (b): Chest & Body
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
X23X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): —
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.): Auto hit culvert at high rate of speed went end over end
20c. TIME OF INJURY: Hour: 6:15 a.m. — Month, Day, Year: 9/17/59
20d. INJURY OCCURRED: While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, off ce bldg., etc.): State Hiss
20f. (City or town): Near Vale Summit — (County): Allegany — (State): Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: R. J. Williams M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒ Acting
EXAMINER'S NAME (Type): R. J. Williams
DATE SIGNED: 9/17/59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9-20-59
22c. NAME OF CEMETERY OR CREMATORY: F'bg. Memorial Park
22d. LOCATION (City, town, or county): Frostburg, (State): Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Joseph R. Durst, ADDRESS: Frostburg, Md.
24a. REC'D BY REGISTRAR DATE: SEP 21 '59
24b. REGISTRAR'S SIGNATURE: Clara E. Frantz

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME
BM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09779

CERTIFICATE OF DEATH

09779

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 2 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 35 South Street

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Oldtown
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Florence Middle: Rebecca Last: Shryock
4. DATE OF DEATH: Month: September Day: 28 Year: 19 59

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]
8. DATE OF BIRTH: July 25 1874
9. AGE (In years last birthday): 85 yrs.
IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HRS: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Town Creek, Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Upton Athey
14. MOTHER'S MAIDEN NAME: Sarah Athey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Mrs. Clara Buser, Address: 35 South Street Cumberland, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Uremia — INTERVAL BETWEEN ONSET AND DEATH: 6 mos
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Arteriosclerosis — 15 yrs
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).
19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work [ ] Not while at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June 19 56 to Sept 28 19 59 that I last saw the deceased alive on Sept. 20 19 59, and that death occurred at 2:00 P. M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Clay E. Durrett M.D.
ADDRESS (Street, city or town, state): 236 Virginia Ave. Cumberland, Maryland
DATE SIGNED:
PHYSICIAN'S NAME (Type): Clay E. Durrett M.D. 236 Virginia Avenue, Cumberland, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Sept. 30, 1959
22c. NAME OF CEMETERY OR CREMATORY: Shryock Cemetery
22d. LOCATION (City, town, or county) (State): Town Creek, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: John J. Hafer, Cumberland, Maryland
24a. REC'D BY REGISTRAR DATE: OCT 2 '59
24b. REGISTRAR'S SIGNATURE: Catherine A. Kane

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 must be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09789

CERTIFICATE OF DEATH

09780
Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1 PLACE OF DEATH
a. COUNTY: ~~CUMBERLAND~~ ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 10 HOURS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: SACRED HEART HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
d. STREET ADDRESS: 1204 S. LEE ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First FLORA Middle ESTELLA Last SMITH

4. DATE OF DEATH: Month SEPT. Day 10 Year 1959

5 SEX: FEMALE
6. COLOR OR RACE: NEGRO
7 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: AUGUST 28, 1899
9. AGE (In years last birthday): 59 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): MARYLAND
12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: THOMAS COOK (DECEASED)
14. MOTHER'S MAIDEN NAME: ELMIRE ~~TAYLOR~~ Sailor (DECEASED)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO: None.
INFORMANT: PATIENTS CHART Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cancer of the ovary — INTERVAL BETWEEN ONSET AND DEATH: 6 months
DUE TO
I 15.0
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from 3-4-, 19 59, to 9-19-, 19 59, that I last saw the deceased alive on 9-10-, 19 59, and that death occurred at 3:50 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: L Brings M.D.
ADDRESS (Street, city or town, state): 57 GREENE ST., CUMBERLAND, MARYLAND
DATE SIGNED
PHYSICIAN'S NAME (Type): LEWIS BRINGS, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b DATE THEREOF: 9/21/59
22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cem
22d. LOCATION (City, town, or county) (State): Cumb. Md.

23 FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Lamb Stein Inc. Cumb. Md
24a. REC'D BY REGISTRAR DATE: SEP 23 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Frank

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09781

CERTIFICATE OF DEATH

09813 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Mt. Savage
c. LENGTH OF STAY IN 1b: 45 Yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Mt. Savage
d. STREET ADDRESS: /
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Frank — Middle — Last Snyder

4. DATE OF DEATH: Month September — Day 1st, — Year 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 12th, 1889

9. AGE (In years last birthday): 70 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret.-oiler Spin.Dept.

10b. KIND OF BUSINESS OR INDUSTRY: Celanese Corp.

11. BIRTHPLACE (State or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Catherine Snyder

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 17-10-7385

INFORMANT Address: Mrs.Margaret B.Snyder, Mt. Savage, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Carcinoma Pancreas — INTERVAL BETWEEN ONSET AND DEATH: 6 months

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

157X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 5/4, 19 59, to 9/1, 19 59, that I last saw the deceased alive on 8/30, 19 59, and that death occurred at 2:30 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Hilda Jane Walters M.D — ADDRESS (Street, city or town, state): 48 Broadway — DATE SIGNED

PHYSICIAN'S NAME (Type): Hilda Jane Walters M.D. Frostburg, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 9-4-59

22c. NAME OF CEMETERY OR CREMATORY: Methodist Cemetery

22d. LOCATION (City, town, or county) (State): Mt. Savage, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Joseph R. Durst, Frostburg, Md.

24a. REC'D BY REGISTRAR DATE: SEP 4 59

24b. REGISTRAR'S SIGNATURE: Clifton E. Kinsel

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VS A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09782

09790 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 45 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): D.O.A. Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
d. STREET ADDRESS: 410 Broadway
e. IS RES. DEC'D ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Orlando — Middle: Ray — Last: Spangler
4. DATE OF DEATH: Month: Sept. — Day: 8 — Year: 19 59

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: March 18, 1886
9. AGE (In years last birthday): 73 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Conductor-retired
10b. KIND OF BUSINESS OR INDUSTRY: Railroad
11. BIRTHPLACE (State or foreign country): Huntington, W. Va.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Jeremiah Spangler
14. MOTHER'S MAIDEN NAME: Sarah

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 705-09-7[illegible]29
17. INFORMANT: Address: Mrs. Mae Spangler, Cumberland, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Unrecorded
420.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Coronary Artery Disease —
DUE TO (c):
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): —
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. —
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.) none
20c. TIME OF INJURY: Hour 8:30 a.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described obave, held an Autopsy ☐, Inspection ☑, Inquiry ☐, and in my opinion death resulted from Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: R. J. Williams M.D
EXAMINER'S NAME (Type): Richard J. Williams, MD
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☑ Acting
DATE SIGNED: 9/10/59

22a. BURIAL CREMATION REMOVAL (Specify): Burial
22b. DATE THEREOF: 9-11-1959
22c. NAME OF CEMETERY OR CREMATORY: Terra Alta Cemetery
22d. LOCATION (City, town, or county) (State): Terra Alta, W. Va.

23. FUNERAL DIRECTOR'S SIGNATURE: James F. Scarpelli
ADDRESS: Cumberland, Md.
24a. REC'D BY REGISTRAR DATE: SEP 14 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09783

09791

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 1 DAY
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution Res'dence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
d STREET ADDRESS: AUBURN AVENUE
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CHARLES Middle W. Last TIPTON

4. DATE OF DEATH: Month SEPTEMBER Day 11 Year 1959

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: AUGUST 1, 1910

9. AGE (In years last birthday): 49 yrs.
IF UNDER 1 YEAR: Months ____ Days ____
IF UNDER 24 HRS: Hours ____ Min ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE Spinner

10b. KIND OF BUSINESS OR INDUSTRY: Textile, Yarn

11. BIRTHPLACE (State or foreign country): WEST VIRGINIA Blaine

12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: CHARLES TIPTON

14. MOTHER'S MAIDEN NAME: BERTHA BARNHART

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 214-07-5488

INFORMANT: WARWICK & Address: MEMORIAL AVENUE
MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION — INTERVAL BETWEEN ONSET AND DEATH: 1 day
420.0
DUE TO (b) ARTERIOSCLEROTIC HEART DISEASE — 6 yrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Old myocardial infarction - 1953

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour ____ o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from ____, 1953, to Sept 11, 1959, that I last saw the deceased alive on Sept 11, 1959, and that death occurred at 6:15 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M D
ADDRESS (Street, city or town, state): 59 GREENE ST
DATE SIGNED: 9/12/59

PHYSICIAN'S NAME (Type): DR. WEISMAN
CUMBERLAND, MD

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b DATE THEREOF: 9-14-59
22c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park
22d. LOCATION (City, town, or county) (State): Cumberland, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: James F. Scarpelli Cumberland, Md.

24a. REC'D BY REGISTRAR DATE: SEP 17 '59

24b. REGISTRAR'S SIGNATURE: [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09784

09792

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 2 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Sacred Heart Hospital

2 USUAL RESIDENCE (Where deceased lived If institution- Res dence before admission)
a. STATE: W. Va. b. COUNTY: Mineral
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Wiley Ford
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Bruce Middle: H. Last: Ward

4. DATE OF DEATH: Month: Sept. Day: 27 Year: 1959

5. SEX: Male

6. COLOR OR RACE: Whie

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 4/5/05

9. AGE (In years last birthday): 54 yrs
IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HRS.: Hours: Min.:

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Tire Repairman

10b KIND OF BUSINESS OR INDUSTRY: Tire Manuf. Co. Tire Manuf. Co.

11. BIRTHPLACE (State or foreign country): W. Va.-Short Gap

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16 SOCIAL SECURITY NO.:

INFORMANT Address: Mrs. Bruce Ward, Wiley Ford, W.Va.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): pneumonia
DUE TO
493X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: 1 day

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): pneumonectomy for bronchiectasis 1954

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 9-23- 19 57, to 9-27- 19 57, that I last saw the deceased alive on 9-26 19 57, and that death occurred at 11:45 PM, from the causes and on the date stated above.

ADDRESS (Street, city or town, state) DATE SIGNED

ACTUAL SIGNATURE: L Brings M.D.

PHYSICIAN'S NAME (Type): Lewis Brings, M.D. 57 Green St., Cumberland, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b DATE THEREOF: 9-30-1959
22c. NAME OF CEMETERY OR CREMATORY: Fort Ashby Cemetery
22d. LOCATION (City, town, or county) (State): Fort Ashby, W. Va.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: James F. Scarpelli, Cumberland, Md.

24a. REC'D BY REGISTRAR DATE: OCT 5 '59

24b. REGISTRAR'S SIGNATURE: Luther L Kramer

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09793 09785

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 2 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 721 Lafayette Avenue

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
d. STREET ADDRESS: 721 Lafayette Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First HOWARD — Middle BROWSON — Last WELLER

4. DATE OF DEATH: Month September — Day 14 — Year 19 59

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Sept. 26, 1876

9. AGE (In years last birthday): 82 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Engineer

10b. KIND OF BUSINESS OR INDUSTRY: B & O Railroad

11. BIRTHPLACE (State or foreign country): Fairview County, Penn.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Hezekiah Weller

14. MOTHER'S MAIDEN NAME: Mary Ellen Allison

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: Howard Weller — Address: Montreal Avenue Cumberland, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: hours
DUE TO (b): Myocarditis & Decompensation — 3 yrs
DUE TO (c):

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour — a. m. p. m. — Month — Day — Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June, 19 58 to Sept 14, 19 59, that I last saw the deceased alive on Sept. 12, 19 59, and that death occurred at 1:30 P. M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Clay E. Durrett M.D. — ADDRESS (Street, city or town, state): 236 Va. Ave Cumberland Md — DATE SIGNED: 9/17/59

PHYSICIAN'S NAME (Type): Clay E. Durrett, M.D. — 236 Virginia Avenue, Cumberland, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Sept. 18, 1959
22c. NAME OF CEMETERY OR CREMATORY: Greenmount Cemetery
22d. LOCATION (City, town, or county) (State): Cumberland, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: John J. Hafer, Cumberland, Maryland

24a. REC'D BY REGISTRAR DATE: SEP 18 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Kimes

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09786

69802 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg
c. LENGTH OF STAY IN 1b: 6 Yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 89½ Braddock Street

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg
d. STREET ADDRESS: 89½ Braddock Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: John — Middle: Robert — Last: Whetstone
4. DATE OF DEATH: Month: September — Day: 24th — Year: 19 59

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Dec. 12th, 1952
9. AGE (In years on last birthday): 6 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): School Boy
10b. KIND OF BUSINESS OR INDUSTRY: School
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James J. Whetstone
14. MOTHER'S MAIDEN NAME: Betty James

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: 89½ Braddock St., James J. Whetstone, Frostburg, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Intracranial Hemorrhage Due
DUE TO (b): To Gun shot Wound - Point
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): of Entry - Base of Nose Toward Rt Eye
INTERVAL BETWEEN ONSET AND DEATH: Sudden.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Deceased + Brother Playing with Rifle at Their Home
20c. TIME OF INJURY: Hour: 9:45 a. m. — Month, Day, Year: Sept 24 59
20d. INJURY OCCURRED: While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home
20f. (City or town) (County) (State): Near Frostburg Allegany Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: W. O. McLane, M D
CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: Sept 25 1959
EXAMINER'S NAME (Type): W. O. McLane,

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9-26-59
22c. NAME OF CEMETERY OR CREMATORY: F'bg. Memorial Park
22d. LOCATION (City, town, or county) (State): Frostburg, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Joseph R. Durst, Frostburg, Md.
24a. REC'D BY REGISTRAR DATE: SEP 28 '59
24b. REGISTRAR'S SIGNATURE: Arthur J. Krause

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09794

CERTIFICATE OF DEATH

09787 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 18 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X LONACONING, MARYLAND
d. STREET ADDRESS: CHARLESTON STREET
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First HOWARD Middle THOMAS Last WILSON

4. DATE OF DEATH: Month SEPTEMBER Day 9 Year 19 59

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: NOVEMBER 19th. 1896

9. AGE (In years last birthday): 62 62 yrs.

IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): UNEMPLOYED

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William WILSON

14. MOTHER'S MAIDEN NAME: REBECCA METZ

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

INFORMANT: WARWICK & MEMORIAL AVENUE MEMORIAL HOSPITAL - CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Squamous cell Carcinoma of Lung

141.9

DUE TO (b): Lung c. widespread Metastasis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: Since Nov '57

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Sept 22, 19 59, to Sept 9, 19 59, that I last saw the deceased alive on Sept 9, 19 59, and that death occurred at 4:40 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: W.F. Williams M.D. ADDRESS (Street, city or town, state): Cumberland Md DATE SIGNED: 9-10-59

PHYSICIAN'S NAME (Type): DR. W.F. WILLIAMS

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 9/12/1959

22c. NAME OF CEMETERY OR CREMATORY: Oak Hill Cemetery

22d. LOCATION (City, town, or county) (State): Lonaconing, MD.

23. FUNERAL DIRECTOR'S SIGNATURE: GEORGE EICHHORN ADDRESS: LONACONING, MD.

24a. REC'D BY REGISTRAR DATE: SEP 14 '59

24b. REGISTRAR'S SIGNATURE: Arthur A. Frank

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09795

09788
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): B&O Railroad Yards, Cumberland Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 Cumberland
d. STREET ADDRESS: Box 80 Potomac Park
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Vermont — Middle: Gilbert — Last: Zollner

4. DATE OF DEATH: Month: Sept. — Day: 3 — Year: 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: April 7, 1923

9. AGE (In years last birthday): 36 yrs.

IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carman Helper

10b. KIND OF BUSINESS OR INDUSTRY: Railroad

11. BIRTHPLACE (State or foreign country): Cumberland, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Oswald G. Zollner

14. MOTHER'S MAIDEN NAME: Clara E. Kaylor

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): yes
(If yes, give war or dates of service): War II

16. SOCIAL SECURITY NO.:

17. INFORMANT: Grant E. Zollner, Cumberland, Md.
Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Gun Shot Wound Head — INTERVAL BETWEEN ONSET AND DEATH: Minutes
976x
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Self inflicted
DUE TO
(c): Mentally ill —

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): —

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Gun shot wound head Self inflicted

20c. TIME OF INJURY: Hour: 6 a. m. p. m. — Month, Day, Year: 9/3/59

20d. INJURY OCCURRED: While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): B&O R.R. Parking Lot

20f. (City or town): Cumb. (County): Allg. (State): Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: R. J. Williams, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒ (acting)

DATE SIGNED: 9/5/59

EXAMINER'S NAME (Type): Dr. Richard J. Williams

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 9-5-1959

22c. NAME OF CEMETERY OR CREMATORY: Davis Memorial Cemetery

22d. LOCATION (City, town, or county): Cumberland, Md. (State):

23. FUNERAL DIRECTOR'S SIGNATURE
ADDRESS: James F. Scarpelli, Cumberland, Md.

24a. REC'D BY REGISTRAR
DATE: SEP 8 '59

24b. REGISTRAR'S SIGNATURE: Esther L Howe

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57